8

IN THE SUPREME COURT

Appeal From The Court of Appeals
Honorable William B. Murphy

ESTATE OF BETTY JEAN SHINHOLSTER, Deceased, by JOHNNIE E. SHINHOLSTER, Personal Representative,

Plaintiff-Appellee,

-vs-

ANNAPOLIS HOSPITAL, assumed name for OAKWOOD UNITED HOSPITALS, INC. a Michigan corporation, ESTATE OF DENNIS E. ADAMS, M .D., Deceased, by KATHERINE ADAMS, Personal Representative, and MARY ELLEN FLAHERTY, M.D.,

Defendants-Appellants.
_____/

Supreme Court Nos. 123720, 123721

Court of Appeals Nos. 225710, 225736

Lower Court No. 97-709041-NH

PLAINTIFF-APPELLEE'S BRIEF ON APPEAL

PROOF OF SERVICE

*** ORAL ARGUMENT REQUESTED ***

MARK GRANZOTTO, P.C.

MARK GRANZOTTO (P31492)
Attorney for Plaintiff-Appellee
414 West Fifth Street
Royal Oak, Michigan 48067
(248) 546-4649

THE THURSWELL FIRM

JUDITH A. SUSSKIND (P40700)
Attorney for Plaintiff-Appellee
1000 Town Center, Suite 500

TABLE OF CONTENTS

Page

INDEX OF AUTHORITIES

Cases **Page**

Statutes

Other Authorities

COUNTERSTATEMENT OF QUESTIONS INVOLVED

I. DID THE TRIAL COURT PROPERLY INSTRUCT THE JURY CONSISTENT WITH EXISTING MICHIGAN LAW THAT MRS. SHINHOLSTER'S CONDUCT PRIOR TO APRIL 7, 1995, THE DATE THAT SHE FIRST PRESENTED FOR TREATMENT WITH THE DEFENDANTS, WAS NOT TO BE CONSIDERED BY THE JURY IN ASSESSING HER COMPARATIVE NEGLIGENCE?

Plaintiff-Appellee says "Yes".

Defendants-Appellants say "No ".

II. ASSUMING THAT MCL 600.1483 APPLIES TO CASES FILED UNDER MICHIGAN'S WRONGFUL DEATH ACT. DID THE TRIAL COURT PROPERLY CONCLUDE THAT PLAINTIFF WAS ENTITLED TO THE HIGHER OF THE TWO LIMITATIONS PLACED ON NONECONOMIC DAMAGES CONTAINED IN MCL 600.1483?

Plaintiff-Appellee says "Yes".

Defendants-Appellants say "No ".

III. DID THE TRIAL COURT PROPERLY CONCLUDE THAT THE JURY'S AWARD OF FUTURE DAMAGES WAS NOT TO BE REDUCED TO PRESENT CASH VALUE BECAUSE OF THE EXPLICIT STATUTORY EXCEPTION TO THE GENERAL RULE CALLING FOR REDUCTION TO PRESENT CASH VALUE CONTAINED IN MCL 600.6311?

Plaintiff-Appellee says "Yes".

Defendants-Appellants say "No ".

STATEMENT OF FACTS

On April 16, 1995, Betty Jean Shinholster suffered a massive stroke. Mrs. Shinholster was paralyzed by that stroke and spent the last four months of her life in a coma, being shuttled between hospitals and nursing homes. In the nine-day period before suffering the stroke which ultimately caused her death, Mrs. Shinholster presented three times to Annapolis Hospital's emergency department complaining of dizziness and ringing in her ears. Yet, on each of these emergency department visits, Mrs. Shinholster was advised that there was nothing seriously wrong with her and she was sent home.

Mrs. Shinholster's medical history insofar as it is relevant to this appeal begins in April 1994, one year before her stroke. In that month, Mrs. Shinholster went to Annapolis Hospital's emergency department for treatment of a boil on her back (Apx. pg. 15b). At that time, Mrs. Shinholster saw Dr. Normita Vicencio. Dr. Vicencio learned that Mrs. Shinholster had high blood pressure (Annapolis Apx. pg. 24A), and she prescribed a drug, Procardia, for Mrs. Shinholster's high blood pressure. Later, Dr. Vicencio prescribed an additional blood pressure medication for Mrs. Shinholster. (Annapolis Apx. pg. 26A).

Over the next five months, Mrs. Shinholster returned to Dr. Vicencio's office for treatment on six different occasions. (*Id.* pgs. 25A-28A). On one of these visits, Mrs. Shinholster acknowledged to Dr. Vicencio that she had not been taking one of the blood pressure pills which Dr. Vicencio had prescribed. (*Id*, p. 26A). During the course of her visits to Dr. Vicencio's office, Mrs. Shinholster's blood pressure continued to be high. However, on the last of these visits, on September 9, 1994, Mrs. Shinholster's blood pressure was measured at 150/100, which was somewhat lower than her prior blood pressure readings. (*Id.* pgs. 53A-54A).

Throughout 1994 and in the first three months of 1995, Mrs. Shinholster was in very good health. (Annapolis Apx. pg. 101A; Apx. pgs. 2b, 12b). However, when Mrs. Shinholster felt well, she tended not to take medications which had been prescribed for her. (Annapolis Apx. pgs. 103A - 104A).

Mrs. Shinholster's period of good health abruptly ended in April 1995. On Friday, April 7, 1995, she began complaining of dizziness and buzzing in her ears. (Annapolis Apx. pg. 76A). Her husband, Johnnie Shinholster, witnessed his wife stumbling and swaying. (Apx. pgs. 4b, 5b, 7b). Mrs. Shinholster told her husband that she had to be taken to a hospital. (Apx. pg. 4b).

Mr. Shinholster took his wife to the Annapolis Hospital's emergency department on the night of April 7, 1995. There, she was treated by Dr. Dennis Adams. At the hospital, Mrs. Shinholster acknowledged that she had a history of high blood pressure and she told Dr. Adams that she had not been taking her blood pressure medication for some time (Annapolis Apx. pgs. 81A; Apx. pg. 1b). The initial blood pressure reading for Mrs. Shinholster on the night of April 7, 1995, was 186/127, an elevated reading. (Annapolis Apx. pg. 77A). Dr. Adams gave Mrs. Shinholster some blood pressure medication and, within ten minutes, her blood pressure level was significantly improved to 153/78 (*Id.* pg. 78A-79A).

Dr. Adams concluded that Mrs. Shinholster's symptoms were being caused by her high blood pressure. (*Id.* pgs. 88A-89A). He discharged Mrs. Shinholster with a prescription for another type of blood pressure medication, Procardia XL-60, and he recommended that she see her family physician within one or two days (*Id.*. pgs. 85A-86A). Mrs. Shinholster was discharged from the Annapolis Hospital emergency department at 10:50 p.m. on Friday, April 7. (*Id.* pg. 84A).

On Monday, April 10, 1995, Mrs. Shinholster experienced a reoccurrence of the symptoms which she had had three days before. On that date, Mr. Shinholster again witnessed his wife swaying and she continued to complain of dizziness and humming in her ears. (Apx. pgs. 6b, 7b). Mrs. Shinholster again considered her symptoms to be serious enough to require treatment at a hospital. Mr. Shinholster took his wife back to the Annapolis Hospital emergency department on the evening of April 10. When she presented to the hospital on that date, hospital records recorded the fact that Mrs. Shinholster was experiencing intermittent dizziness "worsening now". (Annapolis Apx. pg. 89A). Mrs. Shinholster's blood pressure was taken and it was found to be 114/78, a normal reading. (*Id.* pg. 90A).

When Mrs. Shinholster returned to Annapolis Hospital for a second time on April 10, the emergency department doctor on duty was again Dr. Adams (*Id.* pg. 89A). According to hospital records, Mrs. Shinholster arrived in the emergency department between 8:00 p.m. and 8:15 p.m. (*Id.* pg. 92A). She was not seen by Dr. Adams until 2½ hours later, at 10:45 p.m. (*Id*). By the time Dr. Adams saw Mrs. Shinholster, he recorded the fact that she "feels fine now." (Adams Apx. pg. 52a).

Dr. Adams acknowledged that on April 10 he spent "a very, very short period of time" examining Mrs. Shinholster. (Annapolis Apx. pg. 92A). He concluded that the symptoms which Mrs. Shinholster was experiencing on that date were now related to *low* blood pressure and he again decided to release her. (Adams Apx. pgs. 70a, 78a). Hospital records in this case reflect the fact that on April 10, 1995, Dr. Adams did not order any tests in an attempt to determine why Mrs. Shinholster was suffering intermittent symptoms of dizziness and buzzing in her ears.

Four days later, Mrs. Shinholster had to return to Annapolis Hospital's emergency department. On April 14, 1995, Mrs. Shinholster told her husband that she was again feeling

"woozy" and she complained of "rushing" sounds in her ears. (Adams Apx. pgs. 153a-154a). Mr. Shinholster found his wife staggering sufficiently that he had to provide some assistance to her in walking. (Apx. pg. 8b). Mr. Shinholster also had some difficulty understanding his wife's speech. (Apx. pgs. 9b, 13b-14b). Mr. and Mrs. Shinholster arrived at the emergency department at approximately 11:30 p.m. on April 14.

That evening Mrs. Shinholster was treated by another emergency department physician, Dr. Mary Flaherty. The initial blood pressure measurement was recorded as 143/119, (Adams Apx. pg. 154a). Twenty minutes later, before Mrs. Shinholster had been given any medication, Dr. Flaherty took a blood pressure reading and found it to be at the far more acceptable level of 140/80. (*Id*).

Dr. Flaherty, who believed that Mrs. Shinholster's symptoms were related to possible cardiac problems, ordered a number of tests. (*Id.* pgs. 156a-157a, 212a). After doing so, Dr. Flaherty concluded that Mrs. Shinholster had not sustained a heart attack and that she was in no immediate danger. (*Id.* pg. 158a). Dr. Flaherty diagnosed Mrs. Shinholster as having an irregular heartbeat and hypertension, and she concluded that the wooziness and rushing sounds which Mrs. Shinholster was experiencing were due to a drug which she was taking (*Id.* pgs. 162a-163a). Dr. Flaherty ordered Mrs. Shinholster to be discharged in the early morning hours of April 15, 1995, with instructions to stop taking the drug and to follow up with her family doctor (Apx. pgs. 27b-28b).

The next day, April 16, 1995, Mrs. Shinholster was again woozy and again asked her husband to take her back to Annapolis Hospital (Apx. pg. 10b). This time, however, Mrs. Shinholster was not to be released. She was instead admitted to the hospital where she suffered two strokes, the second of which was massive. (Apx. pg. 21b). By the time Dr. Vicencio, Mrs. Shinholster's doctor, visited her in the hospital, Mrs. Shinholster was already comatose, with all four extremities

paralyzed. (Annapolis Apx. pgs. 36A, 39A). Mrs. Shinholster was to remain in this vegetative state for a period of four months. During that period, Mrs. Shinholster was transferred from Annapolis Hospital to a nursing home, but because of her deteriorating condition, she had to be readmitted to the hospital six times. (Apx. pg. 11b) Annapolis Apx. pgs. 42A-46A). Mrs. Shinholster died on August 26, 1995.

Johnnie Shinholster, as the Personal Representative of his wife's estate (hereinafter sometimes referred to as "plaintiff"), filed this action in the Wayne County Circuit Court in March 1997. Plaintiff claimed that Dr. Adams committed medical malpractice with respect to the treatment he provided to Mrs. Shinholster during her April 10, 1995 visit to the Annapolis Hospital emergency department. Mr. Shinholster further claimed that Dr. Flaherty was responsible for malpractice in her treatment of Mrs. Shinholster during her April 14, 1995, emergency department visit.

A jury trial was conducted in this matter before Judge John A. Murphy beginning on August 30, 1999. At that trial, plaintiff presented Dr. Alfred Frankel, a board certified emergency medicine specialist, as an expert witness. Dr. Frankel testified that on April 10, 1995 and April 14, 1995, the applicable standard of care required that Drs. Adams and Flaherty recognize that Mrs. Shinholster was on the verge of a catastrophic stroke and treat her accordingly. According to Dr. Frankel, the defendants should have admitted Mrs. Shinholster to the hospital on April 10th and 15th and, after performing preliminary tests, the defendants should have instituted anti-coagulation therapy, which would have prevented her from suffering her fatal stroke. (Adams Apx. pgs. 111a-134a).

As expressed by Dr. Frankel, the defendants committed malpractice in failing to grasp how precarious Mrs. Shinholster's condition was on April 10 and April 14, and in failing to conclude that she was likely to suffer a stroke. In arriving at this conclusion, Dr. Frankel stressed the importance

of both the symptoms which Mrs. Shinholster reported to the defendants on April 10 and April 14 *and* the fact that Mrs. Shinholster was already a high risk candidate for a stroke. Mrs. Shinholster was at a higher risk for stroke because of her age, her race and, most importantly, because of her history of high blood pressure. (*Id.* pgs. 100a, 113a, 116a). Dr. Frankel confirmed that the single greatest risk factor for a stroke is uncontrolled hypertension. (*Id.* pg. 116a). Thus, based on Mrs. Shinholster's symptoms and her history, Dr. Frankel opined that the defendants had an obligation to do much more in terms of detecting and treating the cause of Mrs. Shinholster's medical problems. He summarized his opinions as follows:

> She is 61 with a history of high blood pressure and she's having symptoms that strongly suggest an impending stroke. She keeps coming back with it.
>
> * * *
>
> How do you distinguish somebody who has potential for a stroke? She has high blood pressure, over 50, symptoms that wax and wane relatively benign, but not acutely sick, not vomiting. This is a lady who is at risk.

(*Id.* pgs. 122a, 124a).

Precisely because a reasonable physician should have recognized that Mrs. Shinholster was a person "at risk" for a stroke, Dr. Frankel testified that both Dr. Adams and Dr. Flaherty breached the applicable standard of care in failing to admit her to the hospital and aggressively treating her for a potential stroke. Dr. Frankel further testified that if Mrs. Shinholster had been admitted to the hospital on either April 10 or April 14 and if her condition had been aggressively treated as the standard of care required, she would not have suffered her fatal stroke. (*Id.* 90a, 92a, 120a, 132a - 134a).

At trial, the defendants called three expert witnesses. All three of these witnesses sharply disputed Dr. Frankel's contention that Drs. Adams and Flaherty breached the applicable standard of care in their treatment of Mrs. Shinholster on April 10 and April 14. These witnesses, however, concurred with Dr. Frankel in one respect. They agreed that if Mrs. Shinholster had been admitted to the hospital by the defendants by April 14, 1995 and if anti-coagulation therapy had been administered, Mrs. Shinholster would not have suffered her fatal stroke. (Annapolis Apx. pgs. 130A-134A; Adams Apx. pg. 338a).

Near the conclusion of the trial, plaintiff's counsel submitted a memorandum in which she argued that under this Court's decision in *Podvin v Eickhorst*, 323 Mich 175; 128 NW2d 563 (1964), the only comparative negligence which the jury could consider was Mrs. Shinholster's negligence occurring after the date she first treated with the defendants. After extensive arguments (Adams Apx. pgs. 344a-375a), the trial judge ruled that Michigan law prohibited the jury from considering any alleged negligence on the part of Mrs. Shinholster occurring before April 7, 1995. The jury was so instructed at the conclusion of the proofs. (*Id.* pgs. 444a-445a).

On September 14, 1999 the jury returned its verdict. The jury concluded that both Dr. Adams and Dr. Flaherty were responsible for medical malpractice which caused Mrs. Shinholster's death. (*Id.* pg. 483a). The jury awarded plaintiff $220,000.00 in past economic damages, $564,600.00 in past noneconomic damages, future economic damages at the rate of $9,700.00 per year for the years 1999 through 2003, and future noneconomic damages of $62,500.00 per year for the years 2000 through 2004. (*Id.* pgs. 483a-486a). The jury further found that Mrs. Shinholster was negligent in her conduct on or after April 7, 1995, and it assessed that comparative negligence at 20%. (*Id.*, pgs. 485a-486a).

The trial court entered a judgment on the jury's verdict on January 4, 2000. Following the denial of their post-judgment motions for new trial, remittitur and/or modification of the judgment, the defendants appealed to the Michigan Court of Appeals. In that court, the defendants raised numerous issues.

On February 14, 2003, the Court of Appeals issued a decision affirming the judgment in its entirety. *Shinholster v Annapolis Hospital*, 255 Mich App 339; 680 NW2d 361 (2003).

ARGUMENT

I. THE COURT OF APPEALS DID NOT ERR IN CONCLUDING THAT THE DEFENDANT COULD NOT CLAIM COMPARATIVE NEGLIGENCE BASED ON MRS. SHINHOLSTER'S CONDUCT WHICH CONTRIBUTED TO THE MEDICAL CONDITION WHICH THE DEFENDANTS WERE NEGLIGENT IN TREATING.

During the course of this trial, the defendants were allowed to introduce evidence of Mrs. Shinholster's medical history predating the defendants' malpractice by approximately one year. The defendants were allowed to present evidence that Mrs. Shinholster had a history of high blood pressure, that she occasionally smoked cigarettes and that she was overweight. (Apx. pgs. 3b, 16b, 17b, 19b, 20b). The defendants were also allowed to produce evidence that, in April 1994, Mrs. Shinholster's physician, Dr. Normita Vicencio, had prescribed blood pressure medication for her, but Mrs. Shinholster did not always take the blood pressure medication which Dr. Vicencio prescribed.

Near the conclusion of the proofs, plaintiff's counsel submitted a Memorandum of Law addressed to the role which comparative negligence would play in the jury's deliberations. In that Memorandum, plaintiff argued that under Michigan law Mrs. Shinholster's allegedly negligent conduct which preceded April 7, 1995 - the date she was first seen by Dr. Adams at Annapolis Hospital - could not be the basis for a finding of comparative negligence.

Following briefing and oral argument, the trial court agreed with plaintiff, ruling that the jury's assessment of Mrs. Shinholster's comparative negligence had to be limited to her conduct after April 7, 1995. As a result, the jury was instructed at the conclusion of the proofs as follows:

> It was the duty of the Plaintiff in connection with this occurrence to use ordinary care for her own safety.

> Members of the jury, the total amount of the damages that the Plaintiff would ever be entitled to recover will be reduced by the percentage of Plaintiff's negligence after April 7th, 1995, that contributed as a proximate cause to her injury.
>
> * * *
>
> Members of the jury, there was evidence in this case regarding the medical habits of the deceased as to whether she followed Dr. Vicenzio's orders and took her medications properly prior to her treatment with Defendant doctors. This evidence may not be the basis for any findings that the deceased was comparatively negligent before April 7, 1995 the date she sought treatment from the Defendants.

(Adams Apx. pg. 445a).

The jury found that Mrs. Shinholster was 20% comparatively negligent on the basis of her post-April 7, 1995 conduct.

The issue which the defendants raise in this Court concerns the propriety of the trial court's comparative negligence instruction. Plaintiff would stress that this issue does not involve any question relating to the exclusion of evidence at trial. Plaintiff did not, for example, object to evidence relating to Mrs. Shinholster's history of failing to take her blood pressure medication, the fact that she was overweight or the fact that she occasionally smoked. Evidence pertaining to these aspects of Mrs. Shinholster's life was admitted without objection from the plaintiff. This evidence was not objected to because, regardless of the trial court's ruling with respect to *comparative negligence*, these facts may be relevant to other aspects of the case, most notably in this case the question of Mrs. Shinholster's life-expectancy.[1] With the appropriate supporting expert testimony, the defendants could have asked the jury to consider Mrs. Shinholster's smoking history, her

---

[1]As indicated in footnote 4, *infra*, a plaintiff's pre-treatment condition may also be relevant to the question of the scope of damages caused by the defendant.

overweight status and her failure to take her blood pressure medicine religiously in calculating how long she would have lived in the absence of the defendants' negligence. Thus, plaintiffs do not contest whether the pre-treatment status of the plaintiff is admissible in evidence, nor does the plaintiff dispute the fact that, properly applied, a jury could consider that pre-treatment status of the plaintiff as a basis for reducing the amount of a plaintiff's recovery. What plaintiff has, however, contested throughout this case is the defendants' argument that Mrs. Shinholster's conduct in the year prior to her treatment by the defendants may be considered as comparative negligence.

A. Michigan Case Law Regarding Comparative Negligence In Medical Malpractice Cases.

Plaintiff does not contest the fact that comparative negligence has a role to play in litigation arising out of professional negligence. Indeed, in making the argument that Mrs. Shinholster's conduct prior to April 7, 1995 could not form the basis for a finding of comparative negligence, plaintiff's counsel conceded at trial that the jury could reduce its award on the basis of Mrs. Shinholster's negligent conduct occurring after April 7, 1995. Thus, plaintiff does not in any way challenge the validity of such cases as *Pietrzyk v City of Detroit*, 123 Mich App 244; 333 NW2d 236 (1983) and *Jalaba v Borovoy*, 206 Mich App 17; 520 NW2d 349 (1994), in which comparative negligence was applied in the context of a medical malpractice action. In these two cases, the plaintiffs sought medical treatment from the defendant and, in furtherance of that treatment, the plaintiffs were advised by their physicians to do or avoid certain things.[2] In both *Pietrzyk* and *Jalaba* the plaintiffs, after receiving medical treatment, failed to do as they were instructed by their

[2]In *Pietrzyk*, the plaintiff was instructed by his doctor to return to the hospital which treated him within three weeks. In *Jalaba*, the plaintiff, following a surgical procedure on her foot, was advised to use crutches and refrain from putting weight on her foot. The plaintiffs in both *Pietrzyk* and *Jalaba* apparently ignored these instructions from their treating physicians.

physicians. In the malpractice trials which followed, the court charged the jury that the plaintiffs' post-treatment failure to do what the defendants had told them to do could constitute comparative negligence. In both *Pietrzyk* and *Jalaba*, these jury instructions were upheld on appeal. *Pietrzyk* and *Jalaba*, therefore, provide unquestioned support for the trial court's determination in this case that Mrs. Shinholster's alleged failure to comply with the instructions given to her by the defendants *after* she first sought treatment from them in April 7, 1995 could be considered by the jury on the question of comparative negligence.

However, the critical issue which was not addressed in either *Pietrzyk* or *Jalaba* concerns the allegedly negligent behavior of the plaintiff which provides the predicate for the plaintiff's decision to seek medical treatment from the defendant in the first instance. This issue has, however, been addressed by the Court in *Podvin v Eickhorst*, 373 Mich 175; 128 NW2d 523 (1964), the primary case relied upon by the trial court in making his ruling regarding comparative negligence. In *Podvin*, the plaintiff was injured in an automobile accident and was taken to a local hospital for treatment of those injuries. In the accident, plaintiff sustained a "dislocated spine" which, according to plaintiff, could have been effectively treated with a surgical procedure, a laminectomy. Because of the defendants' negligence, the laminectomy was not timely performed and, as a result, plaintiff's condition worsened and resulted in his almost complete paralysis from the waist down. The plaintiff in *Podvin* claimed that hospital physicians were responsible for negligence which exacerbated his accident-related injuries.

At the trial on the plaintiff's medical malpractice claims, defense counsel made reference to the plaintiff's fault in causing the automobile accident which led to his hospitalization. In response, plaintiff requested that the trial judge instruct the jury that it was not to consider plaintiff's

negligence associated with the automobile accident in determining if the plaintiff was contributorily negligent. The trial judge refused to give the instruction requested by the plaintiff.

Following a verdict in favor of the defendants, the plaintiff in *Podvin* appealed three issues this Court. Among these issues was the question of whether the trial court had erred in refusing to instruct the jury that the plaintiff's conduct associated with the underlying automobile accident was not to be considered as contributory negligence. The Court in *Podvin* agreed with the plaintiff, ruling that the trial court had committed reversible error in failing to eliminate comparative negligence from the jury's consideration: "Whatever the quoted portion of the instruction given means, it was less than that to which the plaintiff was entitled. *The issue of contributory negligence was not involved in the case.*" 373 Mich at 182 (emphasis added). *See also Sawka v Prokopowycz*, 104 Mich App 829; 306 NW2d 354 (1981) (applying the rationale of *Podvin* to preclude a comparative negligence defense based on plaintiff's smoking in a malpractice action based on the defendant/physician's failure to diagnose lung cancer.)

The rulings in *Podvin* and *Sawka* provided the legal support for the trial court's decision to instruct the jury that Mrs. Shinholster's alleged negligence prior to April 7, 1995 could not be considered as bearing on her comparative negligence. The defendants, however, offer several reasons why this Court should ignore the holdings in these cases.

The defendants first suggest that the Court's contributory negligence ruling in *Podvin* was somehow dictum. This argument is wrong. The *Podvin* opinion begins with the Court's observation that "[w]e need consider only three of the claims of error" raised by the plaintiff therein. 373 Mich at 178. Among the three issues which the Court specifically identified was "the refusal of the trial

judge to instruct the jury, as plaintiff requested that he do, that the case presented no issue of contributory negligence." *Id.*

To be sure, the Court in *Podvin* found other errors which had occurred at trial, but the Court explicitly ruled that all of these errors - including the error associated with the trial court's failure to give the plaintiff's requested contributory negligence instruction - provided the basis for its reversal. After addressing each of the three issues it identified at the outset of the opinion, the *Podvin* decision concluded with the Court's observation that "[f]or the foregoing *errors*, the judgment of no cause . . . must be vacated and a new trial ordered." 373 Mich at 183 (emphasis added). The defendants' suggestion that the *Podvin* ruling is dictum is wrong.

The defendants further claim that *Podvin* is of limited value in this case because the Court's decision in that case "merely states that the issue of contributory negligence was not involved in the case, and that none of the parties had made any claim to the contrary." Adams' Brief, p. 23. Again, this argument seriously misses the mark.

It is true that the defense counsel in *Podvin* did not specifically argue that the plaintiff's pre-treatment negligence constituted contributory negligence. Rather, the Court noted that the defendants in *Podvin* had merely "referred" to the plaintiff's negligence associated with the underlying automobile accident in terms which "openly invited" the jury to find the plaintiff to be at fault for his negligence associated with that accident. 373 Mich at 181. Yet, despite the fact that the defendants in *Podvin* only *intimated* that the jury might translate the plaintiff's negligence associated with the underlying accident into a finding of contributory negligence in his medical malpractice claim, the Court ruled that the plaintiff was entitled to an affirmative instruction that the

jury could *not* consider any pre-treatment negligence on the part of the plaintiff in assessing that negligence.

The defendants' attempts to distinguish the Court's ruling in *Podvin* serves only to highlight just how forceful the *Podvin* Court's ruling was with respect to the jury's consideration of the plaintiff's negligence. In *Podvin,* the defendants did not even formally raise a contributory negligence defense based on plaintiff's pre-treatment negligence and yet this Court ruled that the comments of defendant's counsel during the course of the trial were such that the trial judge had an affirmative obligation to charge the jury that it was not to consider such negligence in assessing the fault of the plaintiff. All that was necessary to require such an instruction was defense counsel's intimation that the jury might consider pre-treatment conduct as negligence. Thus, the fact that contributory negligence was not formally raised the *Podvin* case demonstrates rather dramatically that, where a medical malpractice defendant merely *refers* to pre-treatment misconduct on the part of the plaintiff, the plaintiff is entitled to an affirmative instruction advising the jury that it may not consider as contributory negligence the plaintiff's pre-treatment misconduct which led to the treatment which was (negligently) provided by the defendant.

The defendants further suggest that the ruling announced by the Supreme Court in *Podvin* was the product of evidentiary insufficiency. The defendants opine that "[i]t is possible" that the *Podvin* Court found that there was insufficient evidence to support a claim of contributory negligence. Adams' Brief, p. 23. There is absolutely nothing in the *Podvin* opinion to support this contention. One would certainly presume that if the Michigan Supreme Court in *Podvin* was responding to a failure in the defendants' proofs with respect to the plaintiff's negligence associated with the accident which led to his hospitalization, the Court would have stated so in its opinion.

There is, however, absolutely no mention in the *Podvin* decision with respect to the character of the defendants' proofs regarding the plaintiff's negligence in the accident itself. The Court's complete failure to address the character of defendants' evidence on this point completely refutes any suggestion that the Court's holding in *Podvin* was somehow motivated by an evidentiary insufficiency.

Finally, the defendants urge this Court to ignore the clear holding of *Podvin* by suggesting that that decision, which predated the judicial adoption of comparative negligence by fifteen years, was decided under the rubric of contributory negligence. Thus, the defendants are apparently arguing that the subsequent adoption of comparative negligence principles in *Placek v City of Sterling Heights*, 405 Mich 638; 275 NW2d 511 (1979), somehow undermined the Court's prior ruling in *Podvin*. *Placek*, however, effectuated absolutely no change in the *nature* of the plaintiff's conduct which might be considered by a trier of fact in rendering a verdict. *Placek* changed only the results which flow from a jury's finding that plaintiff was, in fact, negligent. Prior to *Placek* a finding that the plaintiff was negligent resulted in the entry of judgment in favor of the defendant; after *Placek*, such a finding reduced the plaintiff's award, but did not eliminate it. While the Court's adoption of comparative negligence in *Placek* fundamentally altered the *implications* of a jury's determination that the plaintiff was negligent, neither *Placek* in particular nor the comparative negligence doctrine in general made any change in the character of the plaintiff's acts or omissions which could give rise to a finding of negligence against the plaintiff. Thus, the defendants' suggestion that the subsequent adoption of comparative negligence principles in *Placek* somehow altered the Court's previous ruling in *Podvin* is completely unfounded.

B. The Law In Other Jurisdictions Regarding Comparative Negligence

As noted previously, the comparative negligence issues which defendants raise in this appeal concern only the trial court's instruction that the jury was not to consider Mrs. Shinholster's alleged negligence prior to April 1995 in failing to take blood pressure medication which had been prescribed for her by Dr. Vicencio. The defendants contend that, as a result of that negligence, when Mrs. Shinholster presented to the defendants in April 1995, her blood pressure was elevated and, according to the defendants, that elevated blood pressure contributed to her death. Thus, the defendants contend that the jury should have been allowed to consider Mrs. Shinholster's pre-treatment negligence in failing to take her blood pressure medication in assessing her comparative fault. Dr. Frankel, however, testified at trial that Mrs. Shinholster's history of high blood pressure was the very condition which the defendants should have addressed under the applicable standard of care. Thus, what the defendant claims as pretreatment comparative negligence is directly tied to the standard of care imposed on the defendants and, based on the testimony provided in this case, it was the defendants' failure to properly respond to that condition which constituted the malpractice being claimed in this case.

The defendants' argument with respect to Mrs. Shinholster's comparative negligence represents an issue which has arisen in other jurisdictions with considerable frequency. Courts from a number of other states have had to address a question similar to that considered by this Court in *Podvin*: whether a medical malpractice plaintiff whose negligent conduct creates the circumstances for seeking the medical treatment which is the subject of a malpractice claim, may be found to be comparatively negligent on that conduct.

Virtually without exception, the courts which have considered this question have concluded that where the plaintiff's pre-treatment negligence creates the circumstances for the plaintiff to seek medical attention, a doctor who negligently treats the plaintiff cannot claim the plaintiff's pre-treatment conduct as comparative negligence. What follows is a partial list of the cases which have reached this result: *DeMoss v. Hamilton*, 644 NW2d 302 (Iowa 2002); *Harding v Deiss*, 300 Mont 312; 3 P3d 1286 (2000); *Smith v Kennedy*, 2000 WL 968780 (D Kan, 2000); *Huffman v Thomas*, 26 Kan App 685 2d 994 P2d 1072 (1999); *Harvey v Mid-Coast Hospital*, 36 F Supp 2d 32 (D Maine, 1999); *Durphy v Kaiser Foundation Health Plan of Mid-Atlantic States, Inc*, 698 A2d 459 (DC App, 1997); *Fritts v McKinne*, 934 P2d 371 (Okla App, 1997); *Spence v Aspen Skiing Company*, 820 F Supp 542 (D Colo, 1993); *Van Vacter v Hierholzer*, 865 SW2d 355 (Mo App 1993); *Martin v Reed*, 200 Ga App 775; 409 SE2d 874 (1991); *Jensen v Archbishop Bergan Mercy Hospital*, 236 Neb 1; 459 NW2d 138 (1990); *Ostrowski v Azzara*, 111 NJ 429; 545 A2d 148 (1988); *Eiss v Lillis*, 233 Va 545; 357 SE2d 539 (1987); *Cowan v Doering*, 215 NJ Super 484; 522 A2d 444 (1987); *Cheek v Domingo*, 628 F Supp 149 (D V I, 1986); *Owens v Stokoe*, 115 Ill2d 177; 503 NE2d 251; 104 Ill Dec 694 (1986); *Sendejar v Alice Physicians and Surgeons Hospital, Inc*, 555 SW2d 879 (Tex App, 1977); *Matthews v Williford*, 318 SO2d 480 (Fla App, 1975); *See generally*, Orr, *Defense of Patient's Contribution to Fault in Medical Malpractice Actions*, 25 Creighton L Rev 665, 687-689 (1992).

The principle of law reflected in each of these cases has also been adopted in the recently released Restatement addressed to comparative negligence. The applicable provision of the Restatement Torts, 3d, Apportionment of Liability, states that where a physician treats the plaintiff for a medical condition which is caused by the plaintiff's own negligence and the doctor proceeds

to commit malpractice, the doctor cannot claim comparative fault on the part of the plaintiff for the plaintiff's negligent conduct which created the condition which led the plaintiff to seek treatment in the first place. The Restatement comment on this subject provides:"*in a case involving negligent rendition of a service, including medical services, a factfinder does not consider any plaintiff's conduct that created the condition the service was employed to remedy.* Restatement, Torts, 3d, Apportionment of Liability, §7, Comment m (emphasis added).

Thus, this Restatement provision recognizes that where a doctor is confronted with a particular medical condition and proceeds to treat that condition in a professionally negligent manner, that doctor may not escape or reduce his liability for that negligence by asserting that the plaintiff was negligent in creating the condition which led him/her to seek medical treatment. As expressed in the Restatement, "the consequences of the plaintiff's negligence - the medical condition requiring medical treatment - caused the very condition the defendant doctor undertook to treat, so it would be unfair to allow the doctor to complain about that negligence." *Id*, p. 83. In adopting this view, the drafters of the Restatement have indicated that there is not a single reported decision which would support a comparative negligence defense under these circumstances:

> *The consequences of the plaintiff's negligence are sometimes the very conditions a doctor or other service provider agrees to treat.* Examples include a plaintiff who seeks medical treatment for injuries received in an automobile accident negligently caused by the plaintiff, for injuries received in a skiing accident negligently caused by the plaintiff, or by the plaintiff's unreasonable refusal to exercise or eat properly. *No reported case holds that a medical malpractice plaintiff's recovery is barred or reduced because of that type of negligence.*

Id, p. 83 (emphasis added).[3]

In reaching near unanimity on this question of the role which comparative negligence plays in medical malpractice cases, courts around the country have adopted two general reasons as to why the plaintiff's negligence in creating the circumstances which give rise to medical treatment may not be used to establish comparative negligence. The first of these two approaches is reflected in the Restatement commentary cited previously: "[t]he consequences of the plaintiff's negligence are sometimes the very conditions a doctor . . . agrees to treat." Restatement Torts, 3d, Apportionment of Liability, p. 83.

Various courts have, therefore, recognized that where the plaintiff's alleged negligence creates the condition for which treatment is being sought, the plaintiff's negligence in creating this condition cannot be considered as comparative negligence because any contrary rule would relieve defendants of some liability for their negligence in failing to appropriately treat the very conditions

---

[3]Plaintiff would acknowledge that the drafters of the *Restatement*, in making the statement that there were no cases to support a contrary conclusion, failed to take into account the Tennessee Supreme Court's decision in *Gray v Ford Motor Co.*, 914 SW2d 464 (Tenn 1996), a decision which is featured prominently in the defendants' briefs. In *Gray*, the Tennessee Court held that a plaintiff's negligence in causing an automobile accident could be considered by a jury as comparative negligence in a medical malpractice action brought against a doctor who allegedly treated the plaintiff negligently for the injuries arising out of that accident. Plaintiff acknowledges that *Gray* provides support the comparative negligence principles which defendants argue for in this appeal. However, *Gray* represents the *only* case in which this view of the law has been adopted. The reasoning employed by the Tennessee Court in *Gray* is also highly suspect. The essence of the *Gray* Court's ruling is that the injury caused by the automobile accident and the injury caused by the defendant's medical malpractice, which followed that accident, is indivisible. 914 SW2d at 467. This cannot be the law in Michigan. In a case such as *Gray*, where the plaintiff suffers one injury in a car accident and injury is exacerbated by negligent professional care, the plaintiff *cannot* sue the negligent physician for the injury caused in the car accident. The plaintiff may only sue the physician for the *increased* injury resulting from the malpractice itself. Since the plaintiff cannot sue the physician for the injuries caused in the accident itself, the damages which plaintiff actually seeks to recover against the treating physician in a malpractice case must, of necessity, be divisible from those caused in the accident.

which the standard of care compels them to address. This rationale for limiting comparative negligence principles in cases involving professional negligence was aptly summarized by the Tenth Circuit Court of Appeals in *Steiner Corporation v Johnson & Higgins of California*, 135 F3d 684 (10th Cir 1998):

> A professional holding himself out to serve clients or patients is liable for his negligent performance of duties undertaken and may not be relieved of such liability by his clients' or patients' actions in causing or getting involved in the very conditions which the professional was employed and undertook to treat or remedy. *Otherwise the professional would not be held responsible for performing the very duties he assumed.*
>
> 135 F3d at 688 (emphasis added).

Similar reasoning was used by the Montana Supreme Court in *Harding v Deiss, supra.* There, the Court considered a number of cases which have rejected a comparative negligence defense premised on the plaintiff's pre-treatment negligence and it adopted the holdings in these cases for the following reason:

> We agree with the foregoing decisions and conclude that comparative negligence as a defense does not apply where a patient's pretreatment behavior merely furnishes the need for care or treatment which later becomes the subject of a malpractice claim. *The patient's conduct before seeking medical treatment is merely a factor the physician should consider in treating the patient.* . . . Acceptance of [the defendants'] argument would lead to an absurd result. Under such a theory, in any *case where the patient was responsible for events that led to her hospitalization, the treating physician would not be liable for negligent treatment.*
>
> 3 P3d at 1289 (emphasis added).

Or, as stated by the Georgia Court of Appeals in *Martin, supra*:

> What the jury would *not* have been authorized to find is that, although appellees' subsequent treatment and diagnosis did constitute

> malpractice, a recovery therefore was barred because the original automobile wreck had been caused by appellant. *Those patients who may have negligently injured themselves are nevertheless entitled to subsequent non-negligent medical treatment and to an undiminished recovery if such subsequent non-negligent treatment is not afforded.*
>
> 409 SE2d at 877 (emphasis added).

While some of the courts which have addressed this issue have focused on the anomalous results which would follow if doctors could interpose a comparative negligence defense based on the plaintiff's negligence in creating the very conditions which the doctors were obligated by the standard of care to treat, other courts have taken a slightly different approach premised on principles of proximate cause. These courts have held that a plaintiff's alleged negligence in creating the condition which compels him/her to seek medical treatment cannot be considered by the trier of fact because that negligence cannot be a proximate cause of the injury which results from the malpractice.

To understand the proximate cause analysis used by various courts in this context, the Court must understand the nature of the injuries which the plaintiff may recover in a case of this type. Take, for example, the factual situation presented in *Podvin* and numerous other cases: a party is injured in an automobile accident and is taken to a hospital for treatment of his/her injuries. There, malpractice is committed. Obviously, in such a case, a plaintiff suing medical care providers for malpractice may not recover for the injuries sustained in the automobile accident. Rather, the medical malpractice recovery must be limited to the exacerbation of the plaintiff's accident- related injuries occasioned by the defendant's malpractice.[4] The damages which the plaintiff seeks to

[4]This principle is also reflected in the *Restatement* commentary. The *Restatement* indicates that its general rule that a doctor may not claim comparative negligence based on plaintiff's negligence in creating the condition which compels him/her to seek treatment "does not mean the

recover are the damages associated with the malpractice, not the underlying accident.[5] This distinction between the injuries caused by a plaintiff's alleged negligence and a defendant's medical malpractice in the face of that negligence has important implications for purposes of proximate cause.

These implications were cogently addressed by the Florida Court of Appeals in *Mathews v Williford, supra.* In that case, plaintiff's decedent had a heart attack in 1960 and was told by his physician both to stop smoking and to lose weight. He did not heed this advice. In 1970, plaintiff's decedent began to experience chest pains and was admitted to a hospital. However, he was not placed in a cardiac care unit, nor were other precautions taken for a potential heart attack. One day after his admission, plaintiff's decedent died of a massive heart attack. At trial in the medical malpractice case which followed, plaintiff's expert testified that, had reasonable medical steps been taken, plaintiff's heart damage would have been minimized and he would not have died. At trial, the defendant argued that plaintiff's negligence in failing to follow his doctor's warnings regarding

---

plaintiff's 'pre-presentment' negligence is irrelevant. The defendant is liable only for the damages the defendant's negligence caused. Thus, a doctor who treats an accident victim is not liable for the original injury . . ." *Restatement, supra*, p. 83.

[5]Thus, *Podvin* is ultimately much like other types of enhanced injury cases. *Cf Sumner v. General Motors Corp.*, 212 Mich App 694, 698-700; 538 NW2d 112 (1995). In *Sumner,* the Court of Appeals held that in a "crashworthiness" case, a plaintiff bears the burden of distinguishing between the extent of the original injury and the injury caused by the negligence of the vehicle's manufacturer. However, a necessary corollary of *Sumner* is, that, once the plaintiff meets his burden of proof and distinguishes between the injury caused by the initial collision and the enhanced injury caused by the design of the vehicle, the damages being sought against the vehicle's manufacturer is limited solely to the enhanced injuries caused. In such circumstances, the plaintiff's negligence associated with the initial accident is absolutely irrelevant to the manufacturer's negligence since that negligence is not a cause of the damages which the plaintiff is seeking.

smoking and losing weight had to be considered by the trier of fact. The Court in *Matthews* rejected this argument on causation grounds:

> The plaintiff is not claiming damages for the heart attack. The damages she claims, and received from the jury under proper instructions from the court, were the damages for the survival period losses during the life expectancy of the deceased if he had survived, together with damages for the wrongful death, not the heart attack. Any conduct on the part of the plaintiff of the decedent contributing to the heart attack was not a proximate cause of the damages sought in these two actions.
>
> In short, conduct prior to an injury or death is not legally significant in an action for damages like this, unless it is a legal or proximate cause of the injury or death -- as opposed to a cause of the remote conditions or occasion for the later negligence. So it is with conduct of a patient which may have contributed to his illness or medical condition, which furnishes the occasion for medical treatment. That conduct simply is not available as a defense to malpractice which causes a distinct subsequent injury -- here, the ultimate injury, wrongful death.
>
> 404 So2d at 483.

Another case which highlights these causation principles is the Virginia Supreme Court's decision in *Eiss v Lillis, supra.* In *Eiss*, the defendant doctor prescribed a blood thinner, coumadin, for plaintiff's decedent. Shortly thereafter, plaintiff's decedent complained of pain in his leg and another doctor advised him to take aspirin, a drug which also operates as a blood thinner. Two days later, plaintiff's decedent was admitted to the hospital under the defendant's care. There, plaintiff's decedent gave the defendant a complete history, including his use of coumadin and that he had taken aspirin over the prior two days. Despite significant indications that plaintiff's decedent may have been bleeding internally, the defendant took no steps to address this potential life threatening problem. Two days after his admission, plaintiff's decedent died as a result of an intercranial bleed.

At trial in the resulting medical malpractice claim, plaintiff's expert testified that the defendant was negligent in failing to treat the plaintiff's decedent for an obvious intercranial bleed. The defendant doctor asserted that plaintiff's decedent was negligent in taking the aspirin which contributed to the bleeding which caused his death. The Court in *Eiss* rejected the defendant's comparative negligence argument on the ground that the plaintiff's decedent's had not caused the damages which the plaintiff sought to recover:

> Thus, the question is what did Eiss do, if anything, that was shown by his evidence to have been a proximate cause of his death. Dr. Lillis says that Eiss; taking aspirin was a proximate cause of Eiss' death. There was no evidence in the plaintiff's case to support this contention.
>
> *By the time Eiss was readmitted he had already taken the aspirin; he was already bleeding. The aspirin was, by that time, merely a factor that the doctor had to take into consideration in treating Eiss. If aspirin compounds the effect of Coumadin – which the expert testimony shows it does -- then Dr. Lillis, who knew of the Coumadin and of the aspirin, was bound to treat for both.* He cannot successfully contend that he is not liable for Eiss' death because had Eiss not taken aspirin, Eiss would not have needed a doctor. [Plaintiff's expert] testified that *Eiss' history of taking aspirin was all the more reason for Dr. Lillis to have treated him aggressively and with dispatch.*
>
> Were we to accept Dr. Lillis' argument, in any case where the patient was responsible for events that led to his hospitalization, the treating physician would not be liable for negligent treatment. We reject this argument.
>
> *Eiss*, 357 SE2d at 543 (emphasis added).

Thus, in *Eiss*, the Court concluded that a physician who is aware of a patient's alleged negligence and the medical ramifications of that negligence, is obligated to treat the patient for that condition in a non-negligent manner. In such a circumstance, the defendant's negligence in treating

the plaintiff for that known condition severs the causal relationship between plaintiff's pre-treatment negligence and the injuries being claimed as a result of the malpractice.

C. Application Of The Law To The Facts Of This Case.

The trial court ruled that Mrs. Shinholster's alleged negligence prior to April 7, 1995, could not be used in assessing her comparative fault, and he so instructed the jury. In charging the jury in this manner, the trial court was acting consistently with this Court's ruling in *Podvin* and the Court of Appeals' determination in *Sawka*. Moreover, as noted, *supra*, the law which the trial court applied to this case is consistent with the law expressed by every single court which had addressed this question with but one exception.

Furthermore, this case fits squarely within the rationale expressed by various courts as to why comparative negligence in cases of professional negligence may not encompass allegedly negligent conduct which created the medical condition for which the plaintiff sought professional treatment.

The defendants argue that Mrs. Shinholster's failure to take her blood pressure mediation in the year before her April 1995 presentation to Annapolis Hospital constituted comparative negligence on her part. Thus, the defendants take the position that Mrs. Shinholster's high blood pressure contributed to her death. However, the evidence developed in this case demonstrated that, in April 1995 when the acts of malpractice that gave rise to this case occurred, *the defendants were fully aware of the fact that Mrs. Shinholster had a history of high blood pressure and that she had a history of not taking all of her blood pressure medication prescribed for her.* Dr. Adams, who treated Mrs. Shinholster on both April 7 and April 10, acknowledged that he knew of Mrs. Shinholster's history of high blood pressure and that she was not taking the medication which had been prescribed to her for that condition. (Adams Apx. pg. 40a). Thus, when Mrs. Shinholster

presented to Drs. Adams and Flaherty in April 1995, *she presented to them for treatment of the very condition which the defendants claim was caused by Mrs. Shinholster's negligence.* Under these circumstances, the defendants had a duty under the law to treat the condition which Mrs. Shinholster presented with in a non-negligent fashion and they cannot limit that liability by relying on Mrs. Shinholster's alleged negligence in creating the condition which the defendants were obligated by the standard of care to treat.

The testimony provided by plaintiff's expert witness, Dr. Frankel, emphasized this fact. Dr. Frankel testified that the defendants breached the standard of care on April 10 and April 14, 1995, in failing to diagnose an imminent vascular catastrophe. Dr. Frankel testified that when Mrs. Shinholster came to the Annapolis Hospital emergency department on these two dates, she not only arrived with serious symptoms of dizziness and rushing sounds in her ear, she also arrived as a person who had obvious "risk factors" for a stroke. (Adams Apx. pgs. 100a, 113a, 122a-124a). These "risk factors" consisted of her age, her race and, above all, her history of high blood pressure. (*Id.* pgs. 122a-124a). Thus, in Dr. Frankel's view, the defendants breached the applicable standard of care when, in the face of *both* Mrs. Shinholster's presenting symptoms *and* her medical history, they failed to grasp the severity of Mrs. Shinholster's condition. As Dr. Frankel testified, Mrs. Shinholster's continuing symptoms, when combined with her known "risk factors" for stroke, should have led a reasonable physician to diagnose and treat her for a potential vascular catastrophe.

What is of critical importance for purposes of the comparative negligence argument raised by defendants is that *the single greatest risk factor* which identified Mrs. Shinholster as a potential stroke victim was her high blood pressure. (*Id.* pg. 116a). This was not merely the testimony of Dr. Frankel, it was also the testimony provided by Dr. Adams (Annapolis Apx. pg. 82A), Dr. Flaherty

(Apx. pg. 25b, 26b), and the defendants' expert witnesses (Apx. pgs. 30b, 31b). Mrs. Shinholster's history of high blood pressure placed her at risk for a stroke.

In deciding whether the defendants could assert Mrs. Shinholster's pre-April 1995 conduct as comparative negligence, it is absolutely essential to put the nature of the plaintiff's medical malpractice claims into proper prospective. Plaintiff proceeded on the theory that the defendants were negligent in failing to recognize the seriousness of Mrs. Shinholster's condition in April 1995. The gravity of Mrs. Shinholster's medical condition was not merely reflected in her symptoms, it was also reflected in her medical history, *particularly in her history of high blood pressure.* Thus, in the view of plaintiff's expert, *the defendants were negligent in this case in part because they failed to give sufficient weight to the fact that Mrs. Shinholster was at risk for a life threatening stroke precisely because of her high blood pressure.*

Mrs. Shinholster's history of high blood pressure represented a condition which was known to the defendants when they initially treated her in April 1995 and, more importantly, *it was precisely the condition which, according to plaintiff's expert, the defendants should have been responding to by aggressively treating Mrs. Shinholster for a potential stroke.* Mrs. Shinholster's history of not taking blood pressure medication and her history of high blood pressure, therefore, presented the medical background for her seeking treatment from the defendants. The defendants, who were fully aware of both her history of not taking medication and her history of high blood pressure, were charged with the obligation of treating Mrs. Shinholster in a non-negligent fashion for precisely these conditions. The jury concluded that the defendants were negligent in failing to treat Mrs. Shinholster when she presented to them with her symptoms and her medical history. The defendants cannot

attempt to minimize their liability by suggesting that Mrs. Shinholster had the very condition - high blood pressure - which the defendants were obligated to treat in a non-negligent manner.

The comparative negligence argument raised by the defendants herein must be rejected on the basis of the proximate cause issues discussed, *supra.* The case which is perhaps most instructive in demonstrating that there is no proximate cause between Mrs. Shinholster's alleged negligence prior to April 1995 and her death is the Virginia Supreme Court's decision in *Eiss, supra.* In *Eiss*, the defendant asserted that the plaintiff was responsible for some comparative negligence in taking aspirin, a drug which increased the likelihood that the plaintiff, who was already on a potent blood thinning medication, would develop uncontrolled bleeding. The plaintiff saw the defendant doctor several days later and alerted him to the fact that he was taking the aspirin. Despite that knowledge, the defendant doctor did not take steps to address the bleeding problems which could result from the medications which plaintiff was given and that bleeding problem eventually led to the plaintiff's decedent's death.

The Virginia Supreme Court in *Eiss* found that the plaintiff's alleged negligence could not be a proximate cause of the plaintiff's resulting injury. The *Eiss* Court noted that, by the time of the defendant's treatment of the plaintiff, the plaintiff's ingestion of aspirin was "merely a factor that the doctor had to take into consideration in treating" the plaintiff. 357 SE2d at 543. Moreover, the Court in *Eiss* observed that the plaintiff's history of taking aspirin in addition to another anti-coagulation drug was, under the circumstances, "all the more reason for [the defendant] to have treated him aggressively and with dispatch." *Id.*

This case bears a strong resemblance to the facts presented in *Eiss*. Here, the defendants were fully aware of Mrs. Shinholster's alleged negligence in failing to take her blood pressure

medication. Once the defendants knew of that alleged negligence, they had to treat Mrs. Shinholster for it. In the words of the *Eiss* Court, Mrs. Shinholster's high blood pressure was"merely a factor which the [defendants] had to take into consideration in treating" her. Moreover, as Dr. Frankel also explained, the fact that Mrs. Shinholster had symptoms of dizziness and ringing in her ears *combined with* her known history of high blood pressure "was all the more reason for [the defendants] to have treated [her] aggressively and with dispatch." 357 SE2d at 543. Here, assuming that Mrs. Shinholster was negligent with respect to her high blood pressure, the fact remains that she advised the defendants of her "negligence" when she treated with them. The defendants were bound by the applicable standard of care to treat her for that "negligence" and, according to plaintiff's expert, the defendants breached the standard of care precisely because they did not treat Mrs. Shinholster appropriately for her "negligence." Under these circumstances, the defendants' malpractice in failing to treat Mrs. Shinholster in a reasonable manner with respect to the very condition created by her alleged negligence, severs whatever causal link that might exist between her negligence and her ultimate death.

Finally, it is necessary to address the defendants' argument with respect to comparative negligence premised on three Michigan statutes, MCL 600.2957, MCL 600.2959, and MCL 600.6304. The defendants contend that under these statutes, the fault of each person who contributed to an injury must be considered. These statutes, according to the defendants, required the jury to consider all of Mrs. Shinholster's potential "fault", including her failure to take her blood pressure medication.

The unstated premise of the defendants' argument is that these statutes have overruled the decision in *Podvin*, which held that the plaintiff's alleged "fault" which merely creates the

circumstances for subsequent medical treatment may not be considered as comparative negligence in cases where medical treatment was negligently provided. Plaintiff would suggest that this Court should not easily adopt the view that the Michigan Legislature *sub silentio* voided the common law rule reflected in *Podvin*. However, whether this legislation has or has not amended *Podvin*'s assessment of comparative fault, it is quite clear that this legislation does not impact on the trial court's decision to instruct that Mrs. Shinholster's pre-April 1995 "negligence" could not be considered by the jury on the question of her comparative negligence in this particular case.

Of all of the statutes cited in the defendants' briefs, the most important is MCL 600.6304(8), which defines the concept of "fault". That provision states:

> As used in this section, "fault" includes an act, an omission, conduct, including intentional conduct, a breach of warranty, or a breach of a legal duty, or any conduct that could give rise to the imposition of strict liability, *that is a proximate cause of damage sustained by a party.*
>
> *Id.* (emphasis added).

The italicized portion of §6304(8) is of overwhelming importance here. Clearly, for the defendants to claim that Mrs. Shinholster's negligence in not taking her blood pressure medication constituted a jury question with respect to comparative negligence, the defendants must have presented some evidence that this conduct was "a proximate cause of damage sustained by a party." Plaintiff has already discussed in this brief why Mrs. Shinholster's alleged negligence could not have been a proximate cause of the damage which she sustained. Several other observations regarding the language used in §6304(8) are also in order.

Based on the theory of plaintiff's case and the uncontradicted evidence at trial, it was impossible for the defendants to establish that Mrs. Shinholster's alleged negligence in not taking

her blood pressure medication represented "a proximate cause of damage sustained by a party." Mrs. Shinholster's "damage" in this case was, quite obviously, her death. Thus, for the defendants to succeed on their statutory argument, they would have to establish that Mrs. Shinholster's failure to take her blood pressure medication in the year before her death[6] was a proximate cause of her death. This the defendants cannot do.

Plaintiff proceeded in this case on the theory that the defendants should have recognized the gravity of Mrs. Shinholster's medical condition on April 7 and 10, 1995; they should have admitted her to the hospital and administered anti-coagulation therapy. Dr. Frankel testified that if the defendants had done so, Mrs. Shinholster would *not* have suffered her fatal stroke. (Adams Apx. pgs. 90a, 92a, 120a, 132, 134a; Apx. pgs. 18b, 22b-24b). Thus, plaintiff's theory of this case was that, if the defendants had not committed malpractice, Mrs. Shinholster would not have died. In

---

[6]The fact that Mrs. Shinholster's alleged negligence concerns her failure to comply with Dr. Vicencio's 1994 order to take blood pressure medication raises yet another proximate cause issue. The defendants proceed on the assumption that the causal relationship between Mrs. Shinholster's "negligence" and her death was established at trial because, the experts agreed that the stroke which ultimately led to Mrs. Shinholster's death was likely caused by her high blood pressure. This assessment of the necessary causal relationship is wrong. The question for purposes of linking Mrs. Shinholster's "negligence" to her death is not whether her high blood pressure contributed in some way to her death, but whether her high blood pressure *during the year 1994*, when she failed to follow her doctor's advice by not taking medication, caused her death. On this issue it is important to consider the testimony provided by defendant's expert, Dr. Gokli. Dr. Gokli testified with considerable conviction that the disease which killed Mrs. Shinholster "reached that stage not over six months. It took her many, many years to get there." (Adams Apx. pg. 399a). And, he testified that for Mrs. Shinholster's disease to reach the point where she died "she had to have . . . high blood pressure for a very, very long time." (*Id*). Dr. Gokli's testimony was meant to convince the jury that Mrs. Shinholster had a limited life expectancy. Dr. Gokli's testimony, however, had the additional effect of undermining the defendants' proposed causal relationship between Mrs. Shinholster's "negligence" and her death. This is because the defendants had to produce some evidence demonstrating that the course of this long existing disease would have been altered if Mrs. Shinholster had taken her prescribed medication in the year before her death. The defendants did not present proofs on this critical causation question.

other words, Dr. Frankel testified that if the defendants acted in a reasonable manner and did not commit malpractice, Mrs. Shinholster's history of high blood pressure would not have caused her fatal stroke.

The defendants called a number of expert witnesses to rebut various aspects of Dr. Frankel's testimony. The defendants' experts categorically disagreed with Dr. Frankel on many points, including the question of what the standard of care required of Drs. Adams and Flaherty in the course of their treatment of Mrs. Shinholster. Thus, each of the experts called by the defense testified that Dr. Frankel was wrong in claiming that the defendants were responsible for medical malpractice. However, there was one critical point on which the defendants' experts and Dr. Frankel were in agreement. Dr. Frankel testified that Mrs. Shinholster presented to the defendants on April 10 and April 14, 1995 with a completely treatable illness; if the defendant's had properly diagnosed her condition, Mrs. Shinholster would not have died. *The defendants' experts concurred in this testimony.* Dr. Rosner, one of the experts called on behalf of Drs. Adams and Flaherty, confirmed that if Mrs. Shinholster had been admitted to the hospital and anti-coagulation therapy had been administered, *she would not have died.* (Adams Apx. pgs. 267a-269a; Apx. 29b). Another of the defendants' experts, Dr. Bradford Walters, agreed with Dr. Rosner and Dr. Frankel on this point: Mrs. Shinholster would not have died if she had been admitted to the hospital on April 10th or 14th. (Annapolis Apx. pg. 177A).

Thus, while there was considerable disagreement among the expert witnesses called at trial with respect to the applicable standard of care, the uncontradicted testimony presented at trial was that, *if the defendants had complied with the standard of care as testified to by Dr. Frankel, i.e. if they admitted Mrs. Shinholster to the hospital and administered anti-coagulation therapy, Mrs.*

Shinholster would not have died. This means that if the defendants had admitted Mrs. Shinholster to the hospital as Dr. Frankel testified and if anti-coagulation therapy had been ordered, Mrs. Shinholster's history of high blood pressure would not have caused or contributed to her death; she would have survived. The jury found, however, that the defendants breached the standard of care. The defendants failed to ascertain the seriousness of Mrs. Shinholster's condition, they failed to hospitalize her, and they failed to administer anti-coagulation therapy. The jury further found that this breach of the standard of care caused the injury claimed in this case - Mrs. Shinholster's death.

MCL 600.6304(8) provides that a trier of fact is to consider a person's fault that is "a proximate cause of damage sustained by a party." The uncontradicted evidence in this case established that, were it not for the defendants' negligence, Mrs. Shinholster would not have died as a result of her history of high blood pressure. Were it not for the defendants' negligence, Mrs. Shinholster's failure to take her blood pressure medication would not have caused her to die; she would not have suffered the "damage" which was being claimed in this case.

Quite obviously, the jury concluded herein that the defendants had, in fact, breached the applicable standard of care and that this breach caused Mrs. Shinholster's death. But these findings by the jury cannot alter the fact that, were it not for that negligence, Mrs. Shinholster's alleged negligence in failing to take her blood pressure medication would not have been a proximate cause of her death. The cause of Mrs. Shinholster's death was, therefore, the defendants' negligence. In these circumstances, the defendants' negligence was not simply *a* proximate cause of Mrs. Shinholster's death; that negligence was *the* proximate cause of her death.

For all of these reasons, the trial court did not err in refusing to allow the jury to consider Mrs. Shinholster's alleged negligence prior to April 7, 1995 and the Court of Appeals did not err in affirming that decision.

II. TO THE EXTENT THAT THE LIMITATION ON NONECONOMIC DAMAGES SPECIFIED IN MCL 600.1483 APPLIES TO A WRONGFUL DEATH ACTION, IT IS THE HIGHER LIMIT ON NONECONOMIC DAMAGES PROVIDED IN THAT STATUTE WHICH APPLIES TO THIS CASE.

The second issue which defendants raise concerns MCL 600.1483 and its limitation on the recovery of noneconomic damages in medical malpractice cases. The defendants contend that the lower of the two noneconomic damage limitations provided in §1483 applies to this case and to every other wrongful death case.[7]

Before embarking on a discussion of the defendants' arguments, there is a preliminary matter which must be raised. On the same day that leave to appeal was granted in this case, the Court also granted leave to appeal in *Jenkins v Patel*, 469 Mich 958; 671 NW2d 538 (2003). In that case, a panel of the Court of Appeals held that §1483's limitation of noneconomic damages is inapplicable to a wrongful death action. *Jenkins v Patel*, 256 Mich App 112; 662 NW2d 453 (2003). If this Court affirms *Jenkins*, §1483 would not limit the amount of noneconomic damages in any wrongful death case and there will be no reason for the Court to consider the issue which the defendants

---

[7] The reach of the defendants' argument extends beyond wrongful death cases. The wrongful death act applies by its express terms only to those cases where the defendant's negligence causes plaintiff's decedent's death. The defendant's argument, however, would extend to every single case in which a plaintiff injured by medical malpractice does not survive to the date that judgment is entered, regardless of the cause of death.

present in this case - which of the two limitations contained in §1483 applies in a wrongful death action.

The uncontested evidence presented in this case established that Mrs. Shinholster suffered a massive stroke on April 16, 1995, which caused irreparable damage to her brain. (Adams Apx. pgs.135a-136a). As described by Dr. Vicencio, Mrs. Shinholster's treating physician, the stroke left Mrs. Shinholster permanently paralyzed in all four extremities. (Annapolis Apx. pg. 39A). Mrs. Shinholster was to remain in this vegetative state for over four months, until her death on August 26, 1995. (*Id.* pgs. 39A-46A). On the basis of this evidence, plaintiff asserted at trial that the higher damage limitation had to be applied under either §1483(1)(a) or (b).

In making their arguments on appeal, the defendants have not contested the fact that in April 1995 Mrs. Shinholster was rendered a hemiplegic, paraplegic or quadriplegic resulting in a loss of one or more limbs caused by an injury to her brain. Nor have the defendants contested that in April 1995 Mrs. Shinholster suffered permanently impaired cognitive capacity rendering her incapable of making independent life decisions and unable to perform the activities of normal living. The defendants contend, however, that plaintiff may not be awarded damages under the higher cap based on what they describe as a literal reading of §1483(1)(a) and (b). Focusing on the tense of the verbs used in those two subsections, the defendants assert that the higher damage cap applies if the plaintiff *is* hemiplegic, paraplegic or quadriplegic as a result of an injury to the brain for purposes of §1483(a) at the time a judgment is entered, or if the plaintiff *has* permanently impaired cognitive capacity for purposes of §1483(b) at the time a judgment is entered. The defendants contend that the higher cap specified in §1483 cannot be applied to wrongful death actions for the reason that the plaintiff's

injuries, regardless of whether they otherwise meet the requirements of §1483(1)(a) or (b), will always be in the past.

Thus, according to the defendants, even though Mrs. Shinholster spent the last four months of her life a hemiplegic, paraplegic or quadriplegic because of an injury to her brain, she is not entitled to claim the higher cap because, as a result of her death caused by the defendants' negligence, she no longer *is* suffering from that condition. Similarly, the defendants contend that Mrs. Shinholster *has* no permanently impaired cognitive capacity rendering her unable to make independent decisions because the defendants, by causing her death with their negligence, have seen to it that by the time of trial Mrs. Shinholster only *had* that condition which would have qualified her for the higher cap.

The circuit court and the Court of Appeals ruled that the determination of which cap applies under §1483 must be based on the physical condition of the plaintiff resulting from the defendants' malpractice. *Shinholster*, 255 Mich App at 352-356. Thus, because Mrs. Shinholster spent months in a vegetative state as a result of the defendant's malpractice, the Court of Appeals ruled that the higher cap would apply to this case. *Id.*[8]

Because the defendants' textual argument proves illusory, this Court should affirm the Court of Appeals' interpretation of §1483. In making their argument based on the text of §1483, the

---

[8] The Court of Appeals' analysis of §1483 means that those wrongful death actions in which plaintiff satisfies the requests of the higher cap prior to his/her death will be governed by the higher cap, while other wrongful death cases will be subject to the lower cap. This fact disposes of the defendants' arguments regarding legislative attempts to add death as its own category of cases subject to the higher cap. These unsuccessful legislative efforts to change §1483 might at most reflect the view that death, *in and of itself*, does not trigger the higher cap. However, the Court of Appeals did not rule that the higher cap applies to every wrongful death case so the defendants' reference to legislative history and prior contours of the statutory limit or noneconomic damages is not particularly revealing or relevant.

defendants focus exclusively on the language contained in the subsections of that statute, §1483(1)(a) and §1483(1)(b). Taking the language of these two subsections by itself, the defendants fix on the verbs used in these two subsections ("is" and "has") and argue that a plaintiff must, *as of the date of trial or judgment*, have one of the conditions giving rise to the higher cap. However, by examining this language in isolation, the defendants completely ignore the critical language of §1483(1), which precedes these subsections:

> In an action for damages alleging medical malpractice by or against a person or party, the total amount of damages for noneconomic loss recoverable by all plaintiffs, resulting from the negligence of all defendants, shall not exceed $280,000.00 unless, *as the result of the negligence of 1 or more of the defendants*, 1 or more of the following exceptions apply as determined by the court pursuant to section 6304, in which case damages for noneconomic loss shall not exceed $500,000.00:
>
> MCL 600.1483(1) (emphasis added).

Properly reading §1483(1) along with its subsections, §1483(1)(a) and (b), this statute simply states that the lower cap figure applies, "unless, *as the result of the negligence of 1 or more defendants . . . the plaintiff is hemiplegic. . .* resulting in a total permanent functional loss of one or more limbs . . . caused by . . . injury to the brain." MCL 600.1483(1)(a)(i) (emphasis added). Similarly, the statute states that the lower cap figure applies unless, "as *the result of the negligence of one or more of the defendants . . . the plaintiff has permanently impaired cognitive capacity* rendering . . her incapable of making independent, responsible life decisions and permanently incapable of performing the activities of normal, daily living." MCL 600.1483(1)(b) (emphasis added).

Section 1483, therefore, clearly supplies its own temporal frame of reference. To come within the higher cap figure, the statute requires either (1) a finding that as a result of the defendant's negligence the plaintiff is a hemiplegic, paraplegic or quadriplegic, or (2) a finding that as a result of the defendant's negligence, the plaintiff has permanently impaired cognitive capacity. The *temporal frame of reference provided in the statute is obviously associated with the defendants' acts of negligence.* Thus, for purposes of this case the precise question which must be answered to determine the appropriate cap under §1483(1) is whether *as of April 1995* when the defendants committed their acts of professional negligence, the jury could conclude that "as the result of the negligence of one or more of the defendants," Mrs. Shinholster *is* hemiplegic, paraplegic or quadriplegic as a result of a brain injury. Alternatively, the statute compels consideration of the question of whether, as of April 1995, Mrs. Shinholster *has* permanently impaired cognitive capacity.

This reading of the present tense verbs in §1483 is entirely consistent with this Court's opinion in *Michalski v Bar-Levav*, 463 Mich 723; 625 NW2d 754 (2001). In that case, the Court construed provisions of the Handicappers Civil Rights Act, MCL 37.1101, which are also written in the present tense. The Court noted that tense of the verbs in question and ruled that this "present" tense referred not to events existing as of the time of trial, but to events existing during the plaintiff's employment, when her cause of action arose. *Michalski*, 463 Mich at 732-733.

The text of §1483, when read in its totality, does not support the defendants' argument. Quite apart from the literal language of this statue, the Court should also consider the ramifications of the defendants' argument. If the defendants were correct in their reading of §1483, doctors and hospitals who would otherwise be subject to the higher damage cap for injuries caused to a particular plaintiff would, in essence, be rewarded for inflicting the ultimate injury on the plaintiff - death. A doctor

or hospital causing an injury to a person which is serious and permanent enough to fall within the scope of §1483(1)(a) or (b) would be subject to the higher cap. However, another doctor or hospital causing a similarly serious or permanent injury which just happens to kill the patient would be able to claim the benefit of the lower cap.

Moreover, if the defendants were correct in their analysis of §1483(1), the question of which cap would apply would be dependent on factors which are totally unrelated to the serious medical conditions specified in the statute itself. Whatever else can be said of §1483, it is clear that the Legislature intended that the cap on noneconomic damages was supposed to be determined on the basis of the injury caused to the plaintiff by the negligence of a health care professional. However, if defendants are right with respect to how §1483(1) is to be read, the question of which cap controls would be governed less by the condition that a plaintiff is left in as a result of medical malpractice and, instead, governed more by the length of time that it takes for plaintiff's malpractice claim to reach a judgment. If defendants are correct in their interpretation of §1483, an injured party who otherwise satisfies the requirements of §1483(1)(a) and/or (b) to qualify for the higher cap would have to survive until the entry of judgment in order to claim that higher cap. Thus, there will be situations in which the length of time which it takes a particular case to reach judgment–not the character of the plaintiff's injuries–which proves determinative of whether the injured party can claim the higher cap.[9]

---

[9]The defendants' construction of the statute also raises the possibility that in a single piece of litigation and on precisely the same evidence, a medical malpractice case could be transformed from one which is governed by the higher cap to one which is subject to the lower cap. Assume that a plaintiff, who has suffered the type of serious and permanent injury which triggers the higher cap under §1483, proceeds to trial and wins on his/her medical malpractice claim. A judgment is then entered in favor of that plaintiff on the basis of the higher cap. Assume further that the defendant appeals that judgment and, because of error committed at trial, secures a new trial. The case is re-

Consider the law applicable to a person who is rendered a paraplegic by an act of medical negligence who files suit based on that malpractice. While being wheeled into the courthouse to attend the trial of her case, that plaintiff is struck by a car and killed. If defendants' argument with respect to §1483(1) were accepted, this plaintiff would have lost her ability to claim the higher cap award. This hypothetical plaintiff would have lost her right to claim the higher cap not because the injuries she suffered were not sufficiently serious or permanent to meet the requirements of §1483(1)(a) or (b), but because of the utterly fortuitous fact that she died in an unrelated accident before her malpractice claim could be reduced to judgment.

What the defendants envision, therefore, is that the operation of §1483's higher cap will in many cases be entirely dependant on whether the plaintiff prevails in a perverse game of legal "Survivor." If the defendants are right, it may not matter whether the plaintiff suffers one of the serious and permanent injuries specified in §1483(1)(a) or (b). What will, instead, matter is whether the plaintiff manages to survive to the date that a judgment is entered. It is difficult to imagine that the Michigan Legislature enacted §1483 in such a way that the application of the higher cap is less dependent on the character and permanence of the injury inflicted on the plaintiff, than it is on the question of whether the plaintiff survives to judgment.

The Court of Appeals' interpretation of §1483 is both reasonable and consistent with the text of that statute. If, however, this Court is enticed by the intransigent literalism of the defendants' argument, the Court of Appeals' ruling should be reversed. However, if the Court of Appeals'

---

tried on precisely the same evidence bearing on the seriousness and permanence of the plaintiff's injuries. However, by the time of retrial, the plaintiff has died. If defendants are right, despite the same injuries and despite the same evidence, the results in the second case would be dramatically different since the lower cap would apply for the altogether adventitious reason that the plaintiff happened to die in the interim. This is, in a word, absurd.

interpretation of §1483 is to be rejected on the basis of the verb tenses used in §1483, the result in this case will be vastly different than the defendants suggest.

Let us assume for the moment that the defendants' argument is correct and the use of present terse verbs in §1483 dictates that the essential determinations called for by that statute must be assessed in the present tense, *i.e.*, as of the date of trial or judgment. As of the date that the trial took place, Mrs. Shinholster had been resting in her grave for over four years. If the defendants' verb tense infused reading of §1483 were correct, the court or jury deciding which cap on noneconomic damages is to apply would have to decide the following strange, but straightforward questions: (1) *is* Mrs. Shinholster (as she lies in her grave) hemiplegic, paraplegic or quadriplegic, resulting in the functional loss of one or more limbs; or (2) *has* Mrs. Shinholster (as she lies in her grave) a permanently impaired cognitive capacity, rendering her incapable of making independent, responsible life decisions and is she permanently incapable of independently performing the activities of normal, daily living.

One would certainly presume that a judge or jury presented with these questions would conclude that Mrs. Shinholster, like most dead people, has a permanently impaired cognitive capacity which would make it quite difficult for her to make any decisions, including life decisions. Being dead would probably also make it extremely hard for Mrs. Shinholster to perform the activities of normal, daily living. Thus, if the defendants are correct and the literal language of §1483 requires an examination of Mrs. Shinholster's actual condition at the time a verdict is rendered, it would appear that the higher cap would have to apply in *every* action where a defendants' negligence causes death since dead people, as a general rule, experience permanently impaired cognitive capacity.

The courts below, therefore, could have taken the defendants' textual arguments to their logical end and concluded that the higher cap applies in every case in which a party establishes that a person who dies as a result of medical malpractice has a permanently impaired cognitive capacity. The circuit court and the Court of Appeals did not adopt this view. Instead, they focused on the question of whether, as of April 1995 when the defendants' malpractice occurred, Mrs. Shinholster satisfied the conditions set out in §1483(1). Plaintiff would suggest that the lower courts' interpretation of §1483 was correct. But if these decisions were incorrect and the use of the present tense in the verbs contained in that provision proves dispositive, this Court must find that, as of the date of judgment, Mrs. Shinholster, being dead, has a "permanently impaired cognitive capacity rendering her incapable of making independent life decisions and permanently incapable of independently performing the activities of normal daily living." Thus, the higher cap must apply.

III. THE COURT OF APPEALS DID NOT ERR IN REFUSING TO REDUCE THE JURY'S AWARD OF FUTURE DAMAGES TO PRESENT CASH VALUE.

The defendants also contend that the trial court erred in refusing to reduce the jury's future damage award to present cash value. Such a reduction is normally called for by statute. *See* MCL 600.6306(1)(c)(d) and (e). However, the Michigan Legislature enacted a specific exception to the statutory provisions calling for a reduction of future damages. That exception is contained in MCL 600.6311, which states, "sections 6306(1)(c), (d), and (e), 6307 and 6309 do not apply to a plaintiff who is 60 years of age or older at the time of judgment."

MCL 600.6311 is simple and unambiguous; if the plaintiff is over 60 years of age at the time of the entry of judgment, the reduction to present cash value called for by §6306(1) does not apply.

On the basis of MCL 600.6311, the circuit court refused to reduce the future damage award to present cash value because the deceased, Mrs. Shinholster, would have been over 60 years of age as of the date of the judgment. The Court of Appeals affirmed that decision, noting that both Mr. and Mrs. Shinholster were (or would have been) over 60 on the date of the judgment. *Shinholster*, 255 Mich App at 356-357.

The question of how §6311's exception is to be applied focuses on the potential ambiguity associated with that provision's use of the word "plaintiff". In a wrongful death action there are potentially two individuals who might be defined as the "plaintiff", the deceased whose death gives rise to the cause of action or the personal representative who is compelled by statute to bring the case in his/her own name. MCL 600.2922(2).

In their briefs to this Court, the defendants have suggested a third possibility. They claim that the "true" plaintiff in this case is the Estate of Betty Shinholster. They further argue that the Estate is not yet 60 years of age and, therefore, §6311 is inapplicable. This argument is untenable under the text of the wrongful death act, which specifies that every such claim must be "brought by, and in the name of the personal representative of the deceased person." MCL 600.2922(2); *see also* MCL 600.5852 (the wrongful death savings clause, providing that an action which survives by law "may be commenced by the personal representative of the deceased person."); *Maiuri v Sinacola Construction Co.*, 382 Mich 391, 393; 170 NW2d 27 (1969) ("the language of [MCL 600.2922(2)] is mandatory); *cf.* 2.201(B).

Presumably, at some point in time a Michigan appellate court will be presented with a wrongful death action which will demand resolution of the question of whether the word "plaintiff" as used in §6311 refers to the deceased or to the personal representative of the deceased's estate.

But, as the Court of Appeals noted in its decision, while there may be a future case in which this question will have to be addressed, that issue does *not* have to be decided in this case for the simple reason that at the time of the entry of the judgment *both* Mr. Shinholster and Mrs. Shinholster were (or would have been) over 60 years of age. *Shinholster,* 255 Mich App at 357. Therefore, it does not matter how the Court decides this issue. The fact remains that the "plaintiff" in this case was over 60 years of age at the time of judgment and, as a result, the trial court did not err in concluding that the reduction to present cash value called for by MCL 600.6306(1)(c) was inapplicable here.

While it really makes no difference how the Court resolves this question for purposes of this particular case, plaintiff will briefly address the competing arguments as to who is the "plaintiff" in a wrongful death action for purposes of §6311.

Under Michigan's wrongful death act, MCL 600.2922, this action *had* to be brought by Mr. Shinholster as the personal representative of his wife's estate. MCL 600.2922(2). *See Maiuri, supra.* Thus, by law, Mr. Shinholster had to be the plaintiff in this case and he was authorized by both statute, MCL 600.2041, and court rule, MCR 2.201, to assume that role in this case. The wrongful death act would, therefore, give support for the view that Mr. Shinholster is the plaintiff for purposes of §6311.

The Legislature has in several other statutes made clear its intent to apply a statutory provision to the person whose injury is the underlying basis for the case. For example, in MCL 600.2959 the Legislature provided that the amount of a plaintiff's recovery is to be reduced by the "comparative fault of the person upon whose injury or death the damages are based." The same is true in MCL 600.2955a, a statute which provides an absolute defense based on the consumption of drugs or alcohol by "the individual upon whose death or injury the action is based." It is, therefore,

quite clear that the Legislature could have written a statute which referred to the age of the person whose injury gives rise to a wrongful death action. But it did not do so in §6311.

Thus, the literal language of §6311, when construed in light of the requirements of the wrongful death act, appears to support the view that the "plaintiff" for purposes of this case is Mr. Shinholster, the personal representative of his wife's estate. The defendants, however, have properly noted that if the personal representative is the "plaintiff" for purposes of §6311, the reduction to present cash value called for by §6306(1) would be subject to easy manipulation in a wrongful death action. All that would be necessary to avoid the effects of §6306(1) would be for the estate of a deceased person to name a personal representative who is over the age of sixty. Since the "plaintiff" in this scenario would be over age 60, §6311 would dictate that no reduction to present cash value would occur.

The defendants' criticism of an interpretation of §6311 which identifies the personal representative of the estate as the "plaintiff" for purposes of the statute is well taken. Logically, the "plaintiff" for purposes of this provision should be the deceased. That is precisely what the circuit court ruled in this case, holding that it was Mrs. Shinholster's age as of the date of judgment which controlled for purposes of §6311 (Adams Apx. pgs. 493a-496a).

It must be noted, however, that such an interpretation of §6311 flies in the face of that statute's literal language. It must additionally be noted that an interpretation of §6311 which uses the age of the decedent to determine whether a reduction to present cash value occurs, encounters one other problem with respect to the statute's literal language. MCL 600.6311 provides that the reduction to present cash value called for by §6306(1) does not apply "to a plaintiff who *is* 60 years of age or older at the time of judgment." (emphasis added). Taking the tense of the verb used in

§6311 in a completely literal fashion, one would be left with the result that the deceased could never be the "plaintiff" for purposes of that statute since the deceased *is* not sixty years of age at the time of judgment. Thus, a literal reading of §6311 would support the result that the personal representative, who *is* of course living at the time of judgment, must be the "plaintiff" for purposes of §6311.

Obviously, this "interpretation" of §6311 based on the tense of the verb used therein is similar to that which defendants have offered with respect to the appropriate interpretation of MCL 600.1483. For reasons which have been addressed earlier in this Brief, this interpretation of §6311 based on verb tense should not be adopted. However, if the Court is of the view that the verb tense in §1483 somehow governs the interpretation of that statute, this Court would have to come to the conclusion that Mr. Shinholster, as personal representative of his wife's estate, must be the "plaintiff' in this case for purposes of §6311.

Finally, the defendants offer the argument that §6311's exception to §6306(1)'s reduction to present cash value should not apply at all to wrongful death actions. The defendants assert that the purpose behind §6311 is to benefit elderly persons who obtain personal injury judgments. Since in a wrongful death action the proceeds of the recovery may be distributed to beneficiaries who are less than 60 years of age, the defendants contend that the purpose behind §6311 would not be furthered by applying it to a wrongful death action.

There is an insuperable difficulty with defendants' argument based on what the defendants perceive to be the "purpose" behind §6311 or the legislative's "intent" in enacting this provision . That "purpose" or "intent" is directly at odds with the literal language of the statute. The statute's literal language covers every personal injury verdict; it does suggest that there is an exception to its

coverage for causes of action brought under the wrongful death act. To adopt the defendants' argument based on the alleged "purpose" or "intent" behind the statute, the Court would have to substantially rewrite §6311. The Court would have to take a statute which has no exceptions and engraft onto it language specifying that it does not apply to proceeds from a wrongful death claim which are distributed to interested parties who are less than 60 years old.

This Court, of course, is not a body which has the authority to rewrite a statute. Rather, as this Court has emphasized with great frequency, this Court's job is to apply the statute as written by the Michigan Legislature. *Cf. Omne Financial, Inc. v Shacks, Inc,* 460 Mich 305, 311; 596 NW2d 591 (1999) ("nothing may be read into a statute that is not within the manifest intent of the Legislature as derived from the act itself."); *Lesner v Liquid Disposal, Inc.,* 466 Mich 95, 101; 643 NW2d 553 (2002) (a court is to apply the statute "as enacted without addition, subtraction or modification.") *People v McIntyre*, 461 Mich 149, 153; 599 NW2d 102 (1999); *Evans Products Co. v Fry*, 307 Mich 506, 548; 12 NW2d 448 (1943). ("The desirability or the propriety of [a statute] is not for the court. Nor is it for the court to rewrite statute law . . ."). The defendants' request to have §6311 rewritten must ultimately be addressed to the body responsible for any such amendment, the Michigan Legislature.

For each of these reasons, the trial court's determination that the jury's award of future damages was not to be reduced to present cash value on the basis of §6311 should not be disturbed,

RELIEF REQUESTED

Based on the foregoing, Plaintiff-Appellee, JOHNNIE E. SHINHOLSTER, Personal Representative of the Estate of BETTY JEAN SHINHOLSTER, respectfully request that this Court affirm the Court of Appeals' February 14, 2003, decision in its entirety.

Respectfully submitted,

MARK GRANZOTTO, P.C.

MARK GRANZOTTO (P31492)
Attorney for Plaintiff-Appellee
414 W. Fifth Street
Royal Oak, MI 48067-2545
(248) 546-4649

THE THURSWELL FIRM

JUDITH A. SUSSKIND (P40700)
Attorney for Plaintiff-Appellee
1000 Town Center, Suite 500
Southfield, MI 48075
(248) 354-2222

Dated: April 13, 2004